Gemeinsamer Bundesausschuss

Justification

to the Resolution of the Federal Joint Committee (G-BA) on an Amendment of the Pharmaceuticals Directive:
Annex XII – Benefit Assessment of Medicinal Products with New Active Ingredients according to Section 35a SGB V

glofitamab

(new therapeutic indication: diffuse large B-cell lymphoma, relapsed or refractory, combination with gemcitabine and oxaliplatin, ineligible for autologous stem cell transplant)

of 6 November 2025

Contents

1. Legal basis

According to Section 35a paragraph 1 German Social Code, Book Five (SGB V), the Federal Joint Committee (G-BA) assess the benefit of all reimbursable medicinal products with new active ingredients. This includes in particular the assessment of the additional benefit and its therapeutic significance. The benefit assessment is carried out on the basis of evidence provided by the pharmaceutical company, which must be submitted to the G-BA electronically, including all clinical studies the pharmaceutical company have conducted or commissioned, at the latest at the time of the first placing on the market as well as the marketing authorisation of new therapeutic indications of the medicinal product, and which must contain the following information in particular:

1. approved therapeutic indications,
2. medical benefit,
3. additional medical benefit in relation to the appropriate comparator therapy,
4. number of patients and patient groups for whom there is a therapeutically significant additional benefit,
5. treatment costs for the statutory health insurance funds,
6. requirements for a quality-assured application,

The G-BA may commission the Institute for Quality and Efficiency in Health Care (IQWiG) to carry out the benefit assessment. According to Section 35a, paragraph 2 SGB V, the assessment must be completed within three months of the relevant date for submission of the evidence and published on the internet.

According to Section 35a paragraph 3 SGB V, the G-BA decide on the benefit assessment within three months of its publication. The resolution is to be published on the internet and is part of the Pharmaceuticals Directive.

2. Key points of the resolution

The active ingredient glofitamab (Columvi) was listed for the first time on 1 August 2023 in the "LAUER-TAXE®", the extensive German registry of available drugs and their prices.

On 10 April 2025, glofitamab received marketing authorisation for a new therapeutic indication to be classified as a major type 2 variation as defined according to Annex 2, number 2, letter a to Regulation (EC) No. 1234/2008 of the Commission of 24 November 2008 concerning the examination of variations to the terms of marketing authorisations for medicinal products for human use and veterinary medicinal products (OJ L 334, 12.12.2008, sentence 7).

On 9 May 2025, i.e. at the latest within four weeks after informing the pharmaceutical company about the approval for a new therapeutic indication, the pharmaceutical company have submitted a dossier in due time in accordance with Section 4, paragraph 3, number 2 Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV) in conjunction with

Chapter 5 Section 8, paragraph 1, number 2 of the Rules of Procedure (VerfO) of the G-BA on the active ingredient glofitamab with the new therapeutic indication

"Columvi in combination with gemcitabine and oxaliplatin is indicated for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT)."

The G-BA commissioned the IQWiG to carry out the assessment of the dossier. The benefit assessment was published on 15 August 2025 on the G-BA website (www.g-ba.de), thus initiating the written statement procedure. In addition, an oral hearing was held.

The G-BA came to a resolution on whether an additional benefit of glofitamab compared with the appropriate comparator therapy could be determined on the basis of the dossier of the pharmaceutical company, the dossier assessment prepared by the IQWiG, and the statements submitted in the written statement and oral hearing procedure. In order to determine the extent of the additional benefit, the G-BA have evaluated the data justifying the finding of an additional benefit on the basis of their therapeutic relevance (qualitative), in accordance with the criteria laid down in Chapter 5 Section 5, paragraph 7 VerfO. The methodology proposed by the IQWiG in accordance with the General Methods [1] was not used in the benefit assessment of glofitamab.

In the light of the above, and taking into account the statements received and the oral hearing, the G-BA has come to the following assessment:

2.1 Additional benefit of the medicinal product in relation to the appropriate comparator therapy

2.1.1 Approved therapeutic indication of Glofitamab (Columvi) in accordance with the product information

Columvi in combination with gemcitabine and oxaliplatin is indicated for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT).

Therapeutic indication of the resolution (resolution of 6 November 2025):

See the approved therapeutic indication

[1] General Methods, version 7.0 from 19.09.2023. Institute for Quality and Efficiency in Health Care (IQWiG), Cologne.

2.1.2 Appropriate comparator therapy

The appropriate comparator therapy was determined as follows:

a) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) after failure of one line of systemic therapy

Appropriate comparator therapy for glofitamab in combination with gemcitabine and oxaliplatin:

– Tafasitamab in combination with lenalidomide

or

– Polatuzumab vedotin in combination with bendamustine and rituximab

b1) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) and who are eligible for CAR-T cell therapy or allogeneic haematopoietic stem cell transplant after failure of two or more lines of systemic therapy

Appropriate comparator therapy for glofitamab in combination with gemcitabine and oxaliplatin:

An individualised therapy with selection of

- tisagenlecleucel,
- axicabtagene ciloleucel,
- lisocabtagene maraleucel and
- an induction therapy with
  - R-GDP (rituximab, gemcitabine, dexamethasone, cisplatin) *or*
  - R-DHAP (rituximab, dexamethasone, cisplatin, cytarabine) *or*
  - R-ICE (rituximab, ifosfamide, carboplatin, etoposide)

  followed by high-dose therapy with allogeneic stem cell transplantation if there is a response to induction therapy

b2) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for CAR-T cell therapy and haematopoietic stem cell transplant after failure of two or more lines of systemic therapy

Appropriate comparator therapy for glofitamab in combination with gemcitabine and oxaliplatin:

– Tafasitamab in combination with lenalidomide

or

– Polatuzumab vedotin in combination with bendamustine and rituximab

Criteria according to Chapter 5 Section 6 of the Rules of Procedure of the G-BA and Section 6 paragraph 2 Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV):

The appropriate comparator therapy must be an appropriate therapy in the therapeutic indication in accordance with the generally recognised state of medical knowledge (Section 12 SGB V), preferably a therapy for which endpoint studies are available and which has proven its worth in practical application unless contradicted by the guidelines under Section 92, paragraph 1 SGB V or the principle of economic efficiency.

In determining the appropriate comparator therapy, the following criteria, in particular, must be taken into account as specified in Chapter 5 Section 6, paragraph 3 VerfO:

1. To be considered as a comparator therapy, the medicinal product must, principally, have a marketing authorisation for the therapeutic indication.
2. If a non-medicinal treatment is considered as a comparator therapy, this must be available within the framework of the SHI system.
3. As comparator therapy, medicinal products or non-medicinal treatments for which the patient-relevant benefit has already been determined by the G-BA shall be preferred.
4. According to the generally recognised state of medical knowledge, the comparator therapy should be part of the appropriate therapy in the therapeutic indication.

According to Section 6, paragraph 2, sentence 2 Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV), the determination of the appropriate comparator therapy must be based on the actual medical treatment situation as it would be without the medicinal product to be assessed. According to Section 6, paragraph 2, sentence 3 Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV), the G-BA may exceptionally determine the off-label use of medicinal products as an appropriate comparator therapy or as part of the appropriate comparator therapy if it determines by resolution on the benefit assessment according to Section 7, paragraph 4 that, according to the generally recognised state of medical knowledge, this is considered a therapy standard in the therapeutic indication to be assessed or as part of the therapy standard in the medical treatment situation to be taken into account according to sentence 2, and

1. for the first time, a medicinal product approved in the therapeutic indication is available with the medicinal product to be assessed,
2. according to the generally recognised state of medical knowledge, the off-label use is generally preferable to the medicinal products previously approved in the therapeutic indication, or
3. according to the generally recognised state of medical knowledge, the off-label use for relevant patient groups or indication areas is generally preferable to the medicinal products previously approved in the therapeutic indication.

An appropriate comparator therapy may also be non-medicinal therapy, the best possible add-on therapy including symptomatic or palliative treatment, or monitoring wait-and-see approach.

Justification based on the criteria set out in Chapter 5 Section 6, paragraph 3 VerfO and Section 6, paragraph 2 AM-NutzenV:

On 1. In addition to glofitamab in combination with gemcitabine and oxaliplatin (GemOx), the following active ingredients are approved for the present therapeutic indication:

Bleomycin, cyclophosphamide, cytarabine, dexamethasone, doxorubicin, epcoritamab, etoposide, glofitamab as monotherapy, ifosfamide, melphalan, methotrexate, methylprednisolone, mitoxantrone, odronextamab, polatuzumab vedotin, prednisolone, prednisone, tafasitamab, trofosfamide, vinblastine, vincristine, vindesine, rituximab, loncastuximab tesirine, axicabtagene ciloleucel, lisocabtagene maraleucel and tisagenlecleucel.

On 2. According to the S3 guideline, radiotherapy can be a suitable method for local disease control in a palliative setting and should be offered to patients with two or more prior systemic therapies in both study arms, if indicated. An allogeneic stem cell transplant can also be carried out. An autologous stem cell transplant, by contrast, is not an option, as the patients are ineligible for this according to the present therapeutic indication.

On 3. There are resolutions on the benefit assessment of medicinal products with new active ingredients according to Section 35a SGB V.

- Epcoritamab (resolution of 17 April 2025)
- Polatuzumab vedotin (resolution of 20 June 2024)
- Glofitamab (resolution of 1 February 2024)
- Loncastuximab tesirine (resolution of 2 November 2023)
- Lisocabtagene maraleucel (resolutions of 6 April 2023 and 16 November 2023)
- Axicabtagene ciloleucel (resolutions of 3 November 2022, 12 December 2023 and 19 December 2024)
- Tafasitamab (resolution of 3 March 2022)
- Tisagenlecleucel (resolutions of 17 September 2020 and 15 February 2024)
- Polatuzumab vedotin (resolution of 20 August 2020)
- Pixantrone (resolution of 16 May 2013).

On 4. The generally recognised state of medical knowledge was illustrated by a systematic search for guidelines as well as reviews of clinical studies in the present indication and is presented in the "Research and synopsis of the evidence to determine the appropriate comparator therapy according to Section 35a SGB V".

The scientific-medical societies and the Drugs Commission of the German Medical Association (AkdÄ) were also involved in writing on questions relating to the comparator therapy in the present therapeutic indication according to Section 35a, paragraph 7 SGB V.

Among the approved active ingredients listed under 1, only certain active ingredients named below will be included in the appropriate comparator therapy, taking into account the evidence on therapeutic benefit, the guideline recommendations and the reality of care.

It is assumed that patients in this therapeutic indication will generally continue to receive anti-neoplastic treatment, which is why best supportive care is not considered an appropriate comparator therapy.

New draft

The present therapeutic indication generally refers to patients with relapsed/ refractory DLBCL who are ineligible for autologous stem cell transplant and is not restricted with regard to the number of previous lines of therapy.

According to the available evidence, there are distinct treatment recommendations in this regard, depending on the number of previous lines of therapy. The G-BA therefore

consider it appropriate to divide the therapeutic indication into patients after failure of one line of systemic therapy and patients after failure of two or more lines of systemic therapy.

a) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) after failure of one line of systemic therapy

In its recommendations for second-line therapy, the S3 guideline on DLBCL differentiates between patients who are eligible for a high dose and those who are not, and makes differentiated therapy recommendations in each case. The specific recommendations of the S3 guideline for patients eligible for a high dose in the second line of treatment indicate that these are in particular patients who are suitable for high-dose chemotherapy with subsequent autologous stem cell transplant. In contrast, treatment with an allogeneic stem cell transplant is not recommended for the first relapse. In this context, it is consequently assumed that the adults who are ineligible for an autologous stem cell transplant according to the present therapeutic indication are patients who are ineligible for a high dose with respect to the treatment of the first relapse. For these patients, the S3 guideline recommends therapy with a less intensive immunochemotherapy protocol such as the combination of rituximab, gemcitabine and oxaliplatin (R-GemOx) or the combination of tafasitamab and lenalidomide or polatuzumab vedotin in combination with bendamustine and rituximab.

The combination R-GemOx is not approved for this therapeutic indication. Nor can it be inferred from the available evidence that the off-label use of R-GemOx is generally preferable to approved medicinal products according to the generally recognised state of medical knowledge. R-GemOx is therefore not considered as an appropriate comparator therapy.

For the CD19-specific antibody tafasitamab, which is approved in combination with lenalidomide followed by tafasitamab monotherapy for the treatment of adults with relapsed/ refractory DLBCL who are not candidates for autologous stem cell transplant (ASCT), a hint for a non-quantifiable additional benefit was identified in the benefit assessment by resolution of 3 March 2022, since the scientific data did not allow quantification (based on a single-arm study).

Polatuzumab vedotin is approved in combination with bendamustine and rituximab (Pola-BR) for the treatment of adults with relapsed or refractory DLBCL if they are ineligible for a haematopoietic stem cell transplant. By resolution of 20 August 2020, a hint for a non-quantifiable additional benefit of polatuzumab vedotin was identified since the scientific data did not allow quantification. As part of a new benefit assessment because of exceeding the EUR 30 million turnover limit, no additional benefit of polatuzumab vedotin was identified by resolution of 20 June 2024.

In their statements submitted for the present benefit assessment procedure, the scientific-medical societies point out that there are patients who are ineligible for high-dose chemotherapy but are eligible for CAR-T cell therapy. In this context, the two CAR-T cell therapies axicabtagene ciloleucel and lisocabtagene maraleucel have been approved for the treatment of patients with DLBCL that has relapsed or is refractory to first-line chemotherapy within 12 months of completing it. However, the S3 guideline explicitly recommends these two therapy options only for patients who are eligible for a high dose and not for patients who are ineligible for a high dose. In the benefit assessments on

lisocabtagene maraleucel and axicabtagene ciloleucel, no additional benefit was also identified for patients who are ineligible for high-dose therapy and who relapse or are refractory to first-line therapy within 12 months of completing it, compared with therapy according to doctor's instructions (resolutions of 16 November 2023 and 21 December 2023). Taking into account the guideline recommendations and the results of the benefit assessment, axicabtagene ciloleucel and lisocabtagene maraleucel cannot be considered as appropriate comparator therapies for the present patient population.

In the overall assessment, the G-BA therefore determined tafasitamab in combination with lenalidomide or polatuzumab vedotin in combination with bendamustine and rituximab as the appropriate comparator therapy.

Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) after failure of two or more lines of systemic therapy

For the treatment setting after at least two lines of therapy, the S3 guideline includes distinct treatment recommendations for therapy with a primarily curative intent, such as CAR-T cell therapy and stem cell transplant on the one hand, and therapy with a primarily palliative intent on the other.

Autologous stem cell transplant is not considered according to this therapeutic indication. Allogeneic stem cell transplant is considered according to the therapeutic indication and is recommended according to the S3 guideline for patients from the 2nd relapse onwards.

In their statements for the present procedure, the scientific-medical societies point out that there are patients who are ineligible for high-dose chemotherapy but are eligible for CAR-T cell therapy. In addition, the S3 guideline no longer requires the high-dose eligibility of patients for treatment with CAR-T cells from the 2nd relapse onwards. Against this background, the G-BA consider it appropriate to further subdivide - according to the patients' suitability for CAR-T cell therapy - the patient population with relapsed/ refractory DLBCL after failure of two or more lines of systemic therapy.

b1) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) and who are eligible for CAR-T cell therapy or allogeneic haematopoietic stem cell transplant after failure of two or more lines of systemic therapy

According to the S3 guideline, CAR-T cell therapy should be carried out from the second relapse onwards if it has not already been carried out in second-line therapy.

In this regard, axicabtagene ciloleucel and lisocabtagene maraleucel are approved for the treatment of relapsed or refractory DLBCL after two or more lines of systemic therapy. Tisagenlecleucel is also approved in this treatment setting.

A hint of a non-quantifiable additional benefit of tisagenlecleucel was identified in the benefit assessment by resolution of 15 February 2024, since the scientific data did not allow quantification (based on a single-arm study).

In the benefit assessment of axicabtagene ciloleucel, no additional benefit thereof could be identified by resolution of 21 December 2023, as no suitable data were available

compared to the appropriate comparator therapy that would have enabled an assessment of the additional benefit.

No additional benefit of lisocabtagene maraleucel could be identified by resolution of 6 April 2023 either, as no suitable data were available compared to the appropriate comparator therapy that would have enabled an assessment of the additional benefit.

In accordance with the S3 guideline, patients treated with curative intent should also be offered the option of an allogeneic stem cell transplant from the 2nd relapse onwards, following CAR-T cell therapy or if CAR-T cell therapy is not feasible.

According to the current guidelines, the treatment regimens GDP (gemcitabine, dexamethasone, cisplatin), DHAP (dexamethasone, cisplatin, cytarabine) and ICE (ifosfamide, carboplatin, etoposide), each in combination with rituximab (R), are specifically recommended as platinum-based induction chemotherapy. According to the scientific-medical societies, these three combination therapies represent the standard of care and have proven to be equivalent in the context of induction therapy. The protocols R-GDP, R-DHAP and R-ICE have already been used as standard protocols for induction therapy in this therapeutic indication as part of the G-BA's assessment of the "allogeneic stem cell transplant for B-cell non-Hodgkin lymphomas" method.[2]

Rituximab is approved in the present indication but only in combination with CHOP (cyclophosphamide, doxorubicin, vincristine, prednisolone), and individual components of the combination therapies mentioned (cisplatin, carboplatin, gemcitabine) are also not approved in the present indication. Of the active ingredients approved for the treatment of non-Hodgkin lymphoma, only the platinum-free induction therapy MINE (mesna, ifosfamide, mitoxantrone, etoposide), which is mentioned in the American guideline of the National Comprehensive Cancer Network (NCCN) as another possible treatment regimen of lower priority, is available.[3] The statements of the clinical experts in the benefit assessment procedures on axicabtagene ciloleucel for the treatment of relapsed/ refractory DLBCL in the second line of therapy or relapsed/ refractory DLBCL and relapsed/ refractory primary mediastinal large B-cell lymphoma (PMBCL) in the third line of therapy indicate that MINE has no relevant significance in this therapeutic indication and, if used separately in the past, was consolidated with a platinum-containing therapy. In agreement with the estimate of the clinical experts, all the available guidelines unanimously recommend platinum-containing induction therapy with R-GDP, R-ICE or R-DHAP with priority, although it should be noted that the platinum-free induction therapy MINE is not mentioned at all in the S3 guideline relevant especially to the German healthcare context.

In summary, if CAR-T cell therapy has already been carried out or is not an option for medical reasons, salvage chemoimmunotherapy consisting of R-GDP, R-ICE or R-DHAP should be accordingly carried out with the inclusion of stem cell transplant. In these cases, the use of induction therapy with R-GDP, R-ICE or R-DHAP is generally preferable to induction therapy with MINE for this relevant patient group in accordance with Section 6, paragraph 2, number 3 Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV). Therefore, it is appropriate to determine the off-label use of these combinations of medicinal products as the appropriate comparator therapy for this patient population. The other approved active ingredients listed under 1. do not correspond to the therapy

[2] Resolution of the Federal Joint Committee (G-BA) on an Amendment of the Directive on Inpatient Treatment Methods: Allogeneic stem cell transplant for aggressive B-cell non-Hodgkin lymphomas; 9 April 2020
[3] National Comprehensive Cancer Network (NCCN). B-Cell lymphomas; Vers. 05.2022 [online]. Fort Washington (USA): NCCN; 2022. (NCCN Clinical Practice Guidelines in Oncology)

recommendations for the present indication and to the therapy standard in the reality of care as set out in the guidelines and in the written statement of the scientific-medical societies.

In summary, an individualised therapy is determined by selecting induction therapy with R-GDP, R-ICE or R-DHAP, followed by high-dose therapy with allogeneic stem cell transplant if there is a response to induction therapy from the second relapse onwards, as well as the CAR-T cell therapies axicabtagene ciloleucel, lisocabtagene maraleucel and tisagenlecleucel. In consideration of the available evidence, the type and number of previous therapies and the patient's high-dose eligibility must be taken into account for making the treatment decision.

b2) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for CAR-T cell therapy and allogeneic haematopoietic stem cell transplant after failure of two or more lines of systemic therapy

According to the available evidence and the statements of the scientific-medical societies, various chemotherapies or chemoimmunotherapies and targeted substances are therapy options after failure of two or more lines of systemic therapy for patients who are ineligible for either CAR-T cell therapy or a haematopoietic stem cell transplant.

As already explained, tafasitamab is approved for the treatment of patients with relapsed/ refractory DLBCL who are ineligible for an autologous stem cell transplant. By resolution of 3 March 2022, a hint for a non-quantifiable additional benefit of tafasitamab was identified since the scientific data did not allow quantification.

Polatuzumab vedotin is approved in combination with bendamustine and rituximab (Pola-BR), as already explained, for the treatment of adults with relapsed or refractory DLBCL if they are ineligible for a haematopoietic stem cell transplant. It was identified by resolution of 20 June 2024 that the additional benefit of polatuzumab vedotin was not proven.

The active ingredients loncastuximab tesirine and epcoritamab are also available as treatment options in this therapeutic indication. It was determined by the G-BA's resolution of 2 November 2023 that an additional benefit of loncastuximab tesirine is not proven, as no suitable data were available to enable an assessment of the additional benefit. No additional benefit of epcoritamab could be determined by resolution of 17 April 2025 in the benefit assessment following the repeal of the regulatory orphan status, as no suitable data were available. In addition, these two therapy options are not recommended in the S3 guideline. Based on the generally recognised state of medical knowledge, loncastuximab tesirine and epcoritamab are therefore not determined to be appropriate comparator therapies.

The active ingredient odronextamab is a new treatment option in the present therapeutic indication. Odronextamab was approved on 22 August 2024 and has only recently become available in Germany (1 August 2025). Based on the generally accepted state of medical knowledge, odronextamab is not determined to be an appropriate comparator therapy.

Against this background, polatuzumab vedotin in combination with bendamustine and rituximab as well as tafasitamab in combination with lenalidomide are determined to be equally appropriate therapy options.

The findings in Annex XII do not restrict the scope of treatment required to fulfil the medical treatment mandate.

A change in the appropriate comparator therapy requires a resolution by the G-BA linked to the prior review of the criteria according to Chapter 5 Section 6, paragraph 3 Rules of Procedure.

Change in the appropriate comparator therapy

For the originally determined appropriate comparator therapy, it was assumed that the patients in this therapeutic indication are ineligible for high-dose therapy with subsequent autologous or allogeneic stem cell transplant or CAR-T cell therapy.

As part of the written statement procedure, the clinical experts explained that patients who are ineligible for high-dose therapy with subsequent stem cell transplant may however be eligible for CAR-T cell therapy.

In view of the statements of the clinical experts and taking into account the recommendations of the S3 guideline, the differentiated recommendations according to lines of therapy within relapsed or refractory diffuse large B-cell lymphoma on the one hand and the differentiated recommendations according to curative or palliative treatment intent from the second relapse onwards on the other are therefore taken into account when determining the appropriate comparator therapy.

In accordance with the explanations in the S3 guideline from 2022, second-line CAR-T cell therapy is linked to the patients' high-dose eligibility. Despite the statements made by the clinical experts at the oral hearing that CAR-T cells are also increasingly being used in clinical practice for patients who are ineligible for high doses, this is not currently supported by more up-to-date evidence from guidelines[4] for the treatment of the first relapse. In the benefit assessments on lisocabtagene maraleucel and axicabtagene ciloleucel, no additional benefit was also identified for patients who are ineligible for high-dose therapy and who relapse or are refractory to first-line therapy within 12 months of completing it, compared with therapy according to doctor's instructions (resolutions of 16 November 2023 and 21 December 2023). In particular, uncertainties remain as to how high this corresponding percentage of patients in second-line treatment is.

In contrast, in accordance with the recommendations of the S3 guideline, the administration of CAR-T cells from the second relapse onwards for patients treated with curative intent is no longer specifically linked to the patients' high-dose eligibility.

Therefore, for the appropriate comparator therapy, the mentioned CAR-T cell therapies are not determined for the treatment of the first relapse, but for the treatment from the second relapse onwards for correspondingly suitable patients treated with curative intent. In addition, according to the S3 guideline, the allogeneic stem cell transplant for patients treated with curative intent from the second relapse onwards is also determined as a treatment option alongside CAR-T cells as part of an individualised therapy, taking into account high-dose eligibility and the type and number of previous therapies.

The present assessment of the additional benefit of glofitamab in combination with gemcitabine and oxaliplatin remains unaffected by this change in the appropriate comparator therapy.

[4] Alberta Health Services (AHS). Lymphoma; version 20 [online]. Edmonton (CAN): AHS; 2025. [Accessed: 26.03.2025]. (Clinical practice guideline; Band LYHE-002). URL: https://www.albertahealthservices.ca/assets/info/hp/cancer/if-hp-cancer-guidelyhe002-lymphoma.pdf

2.1.3 Extent and probability of the additional benefit

In summary, the additional benefit of glofitamab in combination with gemcitabine and oxaliplatin is assessed as follows:

a) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) after failure of one line of systemic therapy

An additional benefit is not proven.

b1) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) and who are eligible for CAR-T cell therapy or allogeneic haematopoietic stem cell transplant after failure of two or more lines of systemic therapy

An additional benefit is not proven.

b2) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for CAR-T cell therapy and allogeneic haematopoietic stem cell transplant after failure of two or more lines of systemic therapy

An additional benefit is not proven.

Justification:

For the proof of the additional benefit of glofitamab in combination with gemcitabine and oxaliplatin, the pharmaceutical company presented the results of the STARGLO study. The STARGLO study is an ongoing, multicentre, open-label, randomised controlled phase III study, comparing glofitamab in combination with gemcitabine and oxaliplatin to rituximab in combination with gemcitabine and oxaliplatin.

Patients who were refractory or have suffered a relapse after at least one previous systemic therapy are being investigated. Patients for whom only one previous line of therapy had failed were not eligible for a stem cell transplant. Among others, patients who were eligible for CAR-T cell therapy (this only applied to Germany and France) and patients with high-grade B-cell lymphoma with myelocytomatosis oncogene (MYC) and B-cell lymphoma (BCL) 2 and/or BCL6 translocations, with high-grade B-cell lymphoma NOS and with primary mediastinal B-cell lymphoma were excluded from enrolment in the study.

In the dossier, the pharmaceutical company presented the data on the total of 274 patients enrolled, separately for two sub-populations: on patients after failure of first-line therapy and on patients after failure of at least two previous lines of therapy. The STARGLO study was started in February 2021 and is being conducted at 61 study sites in North America, Australia, Europe and Asia.

Assessment:

The data from the STARGLO study are unsuitable for the assessment of the additional benefit. The combination of rituximab in combination with gemcitabine and oxaliplatin constituted the comparator arm of the study. This does not correspond to the determined appropriate

comparator therapy. Consequently, the appropriate comparator therapy has not been implemented.

In the overall assessment, no suitable data are therefore available for an assessment of the additional benefit of glofitamab in combination with gemcitabine and oxaliplatin. An additional benefit of glofitamab in combination with gemcitabine and oxaliplatin versus the appropriate comparator therapy is therefore not proven.

2.1.4 Summary of the assessment

The present assessment is the benefit assessment of a new therapeutic indication for the active ingredient glofitamab.

The therapeutic indication assessed here is as follows:

"Columvi in combination with gemcitabine and oxaliplatin is indicated for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT). "

It was distinguished between the following three patient groups:

a) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) after failure of one line of systemic therapy

b1) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) and who are eligible for CAR-T cell therapy or allogeneic haematopoietic stem cell transplant after failure of two or more lines of systemic therapy

b2) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for CAR-T cell therapy and allogeneic haematopoietic stem cell transplant after failure of two or more lines of systemic therapy

On patient group a)

The G-BA determined tafasitamab in combination with lenalidomide or polatuzumab vedotin in combination with bendamustine and rituximab as the appropriate comparator therapy.

On patient group b1)

An individualised therapy with selection of tisagenlecleucel, axicabtagene ciloleucel and lisocabtagene maraleucel and an induction therapy with R-GDP, R-ICE or R-DHAP followed by a high-dose therapy with an allogeneic stem cell transplant in response to the induction therapy was determined as the appropriate comparator therapy.

On patient group b2)

The G-BA determined tafasitamab in combination with lenalidomide or polatuzumab vedotin in combination with bendamustine and rituximab as the appropriate comparator therapy.

For the proof of the additional benefit of glofitamab in combination with gemcitabine and oxaliplatin, the pharmaceutical company presented the results of the STARGLO study. The STARGLO study is an ongoing, multicentre, open-label, randomised controlled phase III study,

comparing glofitamab in combination with gemcitabine and oxaliplatin to rituximab in combination with gemcitabine and oxaliplatin.

The comparator arm of the study therefore does not correspond to the appropriate comparator therapy of the specific patient groups. Thus, no suitable data are available. It is concluded that an additional benefit of glofitamab in combination with gemcitabine and oxaliplatin for the treatment of adult patients with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) is not proven.

2.2 Number of patients or demarcation of patient groups eligible for treatment

The information on the number of patients is based on the target population in statutory health insurance (SHI).

The G-BA base their resolution on the patient numbers determined by the pharmaceutical company.

The pharmaceutical company's data on the number of patients in the SHI target population are fraught with uncertainty. These result in particular from the fact that

- the numbers from the dossier do not include a restriction to patients with DLBCL not otherwise specified (NOS), contrary to the present indication.
- the pharmaceutical company only consider patients in second and third-line therapy in their derivation, although the therapeutic indication also includes patients in subsequent lines of therapy.
- there are no standardised criteria for eligibility for high-dose therapy and stem cell transplant or CAR-T cell therapy.
- the eligibility for an allogeneic stem cell transplant (alloSCT) in patients who are ineligible for an autologous stem cell transplant (autoSCT) is not explicitly reflected in the derivation of patient numbers. It can be assumed that this aspect does not have a major influence on the numbers, as this group is likely to be patients for whom sufficient collection of stem cells (in preparation for autoSCT) was not even possible.

It is assumed in the overall assessment that the data on the patient groups is in a largely plausible order of magnitude.

2.3 Requirements for a quality-assured application

The requirements in the product information are to be taken into account. The European Medicines Agency (EMA) provides the contents of the product information (summary of product characteristics, SmPC) for Columvi (active ingredient: glofitamab) at the following publicly accessible link (last access: 28 October 2025):

https://www.ema.europa.eu/en/documents/product-information/columvi-epar-product-information_en.pdf

Treatment with glofitamab should only be initiated and monitored by specialists in internal medicine, haematology and oncology, experienced in the treatment of patients with diffuse large B-cell lymphoma (DLBCL).

In accordance with the European Medicines Agency (EMA) requirements regarding additional risk minimisation measures, the pharmaceutical company must provide training material that contains information for medical professionals and patients (incl. patient identification card).

The training material contains, in particular, information and warnings about the cytokine release syndrome.

Obinutuzumab is not approved for pretreatment prior to starting therapy with glofitamab. The application for marketing authorisation was withdrawn. Obinutuzumab is not reimbursable for this indication.

2.4 Treatment costs

The treatment costs are based on the contents of the product information and the information listed in the LAUER-TAXE® (last revised: 1 September 2025). The calculation of treatment costs is generally based on the last revised LAUER-TAXE® version following the publication of the benefit assessment.

The annual treatment costs shown refer to the first year of treatment.

If no maximum treatment duration is specified in the product information, the treatment duration is assumed to be one year (365 days), even if the actual treatment duration varies from patient to patient and/or is shorter on average. The time unit "days" is used to calculate the "number of treatments/ patient/ year", time intervals between individual treatments and for the maximum treatment duration, if specified in the product information.

For the cost representation, only the dosages of the general case are considered. Patient-individual dose adjustments (e.g. because of side effects or co-morbidities) are not taken into account when calculating the annual treatment costs.

According to the product information for glofitamab, all patients are pretreated with a single dose of obinutuzumab (1,000 mg) on day 1, cycle 1[5].

CAR-T cell therapies

[5] Obinutuzumab is not approved for pretreatment prior to therapy with glofitamab. The application for marketing authorisation was withdrawn. Obinutuzumab is not reimbursable for this indication, which is why the necessary costs cannot be quantified.

Axicabtagene ciloleucel, lisocabtagene maraleucel and tisagenlecleucel are genetically modified, patient's own (autologous) T cells, which are usually obtained by leukapheresis. Since leukapheresis is part of the manufacture of the medicinal product according to Section 4 paragraph 14 Medicinal Products Act, no further costs are incurred in this respect for these active ingredients as treatment options of the medicinal product to be assessed.

Axicabtagene ciloleucel, lisocabtagene maraleucel and tisagenlecleucel are listed on LAUER-TAXE®, but are only dispensed to appropriately qualified inpatient treatment facilities. Accordingly, the active ingredients are not subject to the Pharmaceutical Price Ordinance (Arzneimittelpreisverordnung) and no rebates according to Section 130 or Section 130a SGB V apply. The calculation is based on the purchase price of the respective clinic pack, in deviation from the LAUER-TAXE® data usually taken into account.

Axicabtagene ciloleucel, lisocabtagene maraleucel and tisagenlecleucel are administered as a single intravenous infusion according to the requirements in the underlying product information.

Induction chemotherapy before stem cell transplantation

The induction chemotherapies R-GDP (rituximab + gemcitabine + dexamethasone + cisplatin), R-ICE (rituximab + ifosfamide + carboplatin + etoposide) and R-DHAP (rituximab + dexamethasone + cytarabine + cisplatin) do not have a marketing authorisation in the present therapeutic indication. In accordance with the recommendation of the S3 guideline, the G-BA uses 2 – 3 cycles as the basis for calculating costs in the context of off-label use of these combination therapies[6]. Furthermore, for the treatment regimens and dosages in relation to the combination therapy R-GDP, the study by Crump et al. (2014) [7] referenced in the S3 guideline and, in relation to the combination therapies R-ICE and R-DHAP, the study by Gisselbrecht et al. referenced in the S3 guideline (2010)[8] are taken into account.

Inpatient treatments

Some treatment options of the appropriate comparator therapy are carried out on an inpatient basis. The inpatient costs are calculated on the basis of the case flat fee revenues, which result from the valuation ratios of the respective DRG (Diagnosis Related Group) multiplied by the federal base rate value of 2025 (€ 4,394.22). Furthermore, the nursing revenue, which is calculated from the average length of stay of the concerned Diagnosis Related Group (DRG) multiplied by the nursing fee according to Section 15 paragraph 2a German Hospital Fee Act (KHEntgG) and the treatment-specific nursing revenue valuation ratio, is taken into account in the inpatient costs.

[6] Association of the Scientific-Medical Societies (AWMF). Diagnostics, therapy and follow-up for adult patients with diffuse large B-cell lymphoma and related entities; S3-guideline [online]. AWMF register number 018-038OL. Berlin (GER): Oncology guideline programme; 2022.

[7] Crump M, Kuruvilla J, Couban S, MacDonald D, Kukreti V, Kouroukis C, et al. Randomized comparison of gemcitabine, dexamethasone, and cisplatin versus dexamethasone, cytarabine, and cisplatin chemotherapy before autologous stem-cell transplantation for relapsed and refractory aggressive lymphomas: NCIC-CTG LY12. J Clin Oncol. 2014;32:3490-6.

[8] Gisselbrecht C, Glass B, Mounier N, Singh Gill D, Linch DC, Trneny M, et al. Salvage regimens with autologous transplantation for relapsed large B-cell lymphoma in the rituximab era. J Clin Oncol 2010;28 (27):4184-90

Treatment period:

a) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) after failure of one line of systemic therapy

Designation of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
Medicinal product to be assessed				
Glofitamab in combination with gemcitabine and oxaliplatin				
glofitamab	Cycle 1: 2 x per 21-day cycle Cycle 2 – 12: 1 x per 21-day cycle	12.0	Cycle 1: 2 Cycle 2 – 12: 1	13
Gemcitabine	1 x per 21-day cycle	8.0	1	8
Oxaliplatin	1 x per 21-day cycle	8.0	1	8
Appropriate comparator therapy				
Tafasitamab in combination with lenalidomide				
Tafasitamab	Combination therapy 28-day cycle; Cycle 1: Day 1, 4, 8, 15 and 22 Cycle 2 + 3: Day 1, 8, 15 and 22 Cycle 4 – 12: Day 1 and 15	12.0	Cycle 1: 5 Cycle 2 + 3: 4 Cycle 4 – 12: 2	31.0
	Monotherapy 28-day cycle; Day 1 and 15	1.0	2	2.0
Lenalidomide	Day 1 – 21 of a 28-day cycle	12.0	21	252
Polatuzumab vedotin in combination with bendamustine and rituximab				
Polatuzumab vedotin	1 x per 21-day cycle	6.0	1	6
Bendamustine	2 x per 21-day cycle	6.0	2	12
Rituximab	1 x per 21-day cycle	6.0	1	6

b1) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) and who are eligible for CAR-T cell therapy or allogeneic haematopoietic stem cell transplant after failure of two or more lines of systemic therapy

Designation of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
Medicinal product to be assessed				
Glofitamab in combination with gemcitabine and oxaliplatin				
glofitamab	Cycle 1: 2 x per 21-day cycle Cycle 2 – 12: 1 x per 21-day cycle	12.0	Cycle 1: 2 Cycle 2 – 12: 1	13
Gemcitabine	1 x per 21-day cycle	8.0	1	8
Oxaliplatin	1 x per 21-day cycle	8.0	1	8
Appropriate comparator therapy				
CAR-T cell therapies				
Axicabtagene ciloleucel	Single dose	1	1	1
Lisocabtagene maraleucel	Single dose	1	1	1
Tisagenlecleucel	Single dose	1	1	1
Induction chemotherapy followed by high-dose chemotherapy with allogeneic stem cell transplant if there is a response to induction chemotherapy				
Induction therapy				
R-GDP (rituximab + gemcitabine + dexamethasone + cisplatin) [7]				
Rituximab	1 x per 21-day cycle (day -1)	2 – 3	1	2 – 3
Gemcitabine	2 x per 21-day cycle (day 1 + 8)	2 – 3	2	4 – 6
Dexamethasone	4 x per 21-day cycle (day 1 - 4)	2 – 3	4	8 – 12
Cisplatin	1 x per 21-day cycle (day 1)	2 – 3	1	2 – 3
R-ICE *(rituximab + ifosfamide + carboplatin + etoposide)*[8]				
Rituximab	1 x per 21-day cycle (day 1; additionally once on	2 – 3	1	3 – 4

Designation of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
	the day before the first cycle)			
Ifosfamide	1 x per 21-day cycle (day 2)	2 – 3	1	2 – 3
Carboplatin	1 x per 21-day cycle (day 2)	2 – 3	1	2 – 3
Etoposide	3 x per 21-day cycle (day 1 – 3)	2 – 3	3	6 – 9
R-DHAP (rituximab + dexamethasone + cytarabine + cisplatin) [7,8]				
Rituximab	1 x per 21-day cycle (day 1; additionally once **optionally** on the day before the first cycle)	2 – 3	1	2 – 4
Dexamethasone	4 x per 21-day cycle (day 1 – 4)	2 – 3	4	8 – 12
Cytarabine	2 x on day 2 of a 21-day cycle	2 – 3	1	2 – 3
Cisplatin	1 x per 21-day cycle (day 1)	2 – 3	1	2 – 3
High-dose chemotherapy with allogeneic stem cell transplant				
Highly complex and intensive block chemotherapy	once		7.9 (average length of stay)	7.9
Allogeneic stem cell transfusion	once		33.6 (average length of stay)	33.6

b2) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for CAR-T cell therapy and allogeneic haematopoietic stem cell transplant after failure of two or more lines of systemic therapy

Designation of the therapy	Treatment mode	Number of treatments/ patient/ year	Treatment duration/ treatment (days)	Treatment days/ patient/ year
Medicinal product to be assessed				
Glofitamab in combination with gemcitabine and oxaliplatin				
glofitamab	Cycle 1: 2 x per 21-day cycle Cycle 2 – 12: 1 x per 21-day cycle	12.0	Cycle 1: 2 Cycle 2 – 12: 1	13
Gemcitabine	1 x per 21-day cycle	8.0	1	8
Oxaliplatin	1 x per 21-day cycle	8.0	1	8
Appropriate comparator therapy				
Tafasitamab in combination with lenalidomide				
Tafasitamab	Combination therapy 28-day cycle; Cycle 1: Day 1, 4, 8, 15 and 22 Cycle 2 + 3: Day 1, 8, 15 and 22 Cycle 4 – 12: Day 1 and 15	12.0	Cycle 1: 5 Cycle 2 + 3: 4 Cycle 4 – 12: 2	31.0
	Monotherapy 28-day cycle; Day 1 and 15	1.0	2	2.0
Lenalidomide	Day 1 – 21 of a 28-day cycle	12.0	21	252
Polatuzumab vedotin in combination with bendamustine and rituximab				
Polatuzumab vedotin	1 x per 21-day cycle	6.0	1	6
Bendamustine	2 x per 21-day cycle	6.0	2	12
Rituximab	1 x per 21-day cycle	6.0	1	6

Consumption:

For dosages depending on body weight (BW) or body surface area (BSA), the average body measurements of the official representative statistics "Microcensus 2021 – body measurements of the population" were applied (average body height: 1.72 m; average body weight: 77.7 kg). This results in a body surface area of 1.91 m² (calculated according to Du Bois 1916).[9]

a) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) after failure of one line of systemic therapy

Designation of the therapy	Dosage/ application	Dose/ patient/ treatment days	Consumption by potency/ treatment day	Treatment days/ patient/ year	Average annual consumption by potency
Medicinal product to be assessed					
Glofitamab in combination with gemcitabine and oxaliplatin					
glofitamab	Cycle 1: Day 8: 2.5 mg	Cycle 1: Day 8: 2.5 mg	1 x 2.5 mg	1	1 x 2.5 mg + 34 x 10 mg
	Cycle 1: Day 15: 10 mg	Cycle 1: Day 15: 10 mg	1 x 10 mg	1	
	Cycle 2 – 12: Day 1: 30 mg	Cycle 2 – 12: Day 1: 30 mg	3 x 10 mg	11	
Gemcitabine	1,000 mg/m² = 1,910 mg	1,910 mg	2 x 1,000 mg	8	16 x 1,000 mg
Oxaliplatin	100 mg/m² = 191 mg	191 mg	1 x 200 mg	8	8 x 200 mg
Appropriate comparator therapy					
Tafasitamab in combination with lenalidomide					
Tafasitamab	12 mg/kg = 932.4 mg	932.4 mg	5 x 200 mg	33.0	165 x 200 mg
Lenalidomide	25 mg	25 mg	1 x 25 mg	252	252 x 25 mg
Polatuzumab vedotin in combination with bendamustine and rituximab					
Polatuzumab vedotin	1.8 mg/kg = 139.9 mg	139.9 mg	1 x 140 mg	6	6 x 140 mg
Bendamustine	90 mg/m² = 171.9 mg	171.9 mg	1 x 100 mg + 3 x 25 mg	12	12 x 100 mg + 36 x 25 mg

[9] Federal health reporting. Average body measurements of the population (2021, both sexes, 15 years and older), www.gbe-bund.de

Designation of the therapy	Dosage/ application	Dose/ patient/ treatment days	Consumption by potency/ treatment day	Treatment days/ patient/ year	Average annual consumption by potency
Rituximab	375 mg/m² = 716.3 mg	716.3 mg	1 x 500 mg + 3 x 100 mg	6	6 x 500 mg + 18 x 100 mg

b1) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT) and who are eligible for CAR-T cell therapy or allogeneic haematopoietic stem cell transplant after failure of two or more lines of systemic therapy

Designation of the therapy	Dosage/ application	Dose/ patient/ treatment days	Consumption by potency/ treatment day	Treatment days/ patient/ year	Average annual consumption by potency
Medicinal product to be assessed					
Glofitamab in combination with gemcitabine and oxaliplatin					
glofitamab	Cycle 1: Day 8: 2.5 mg	Cycle 1: Day 8: 2.5 mg	1 x 2.5 mg	1	1 x 2.5 mg + 34 x 10 mg
	Cycle 1: Day 15: 10 mg	Cycle 1: Day 15: 10 mg	1 x 10 mg	1	
	Cycle 2 – 12: Day 1: 30 mg	Cycle 2 – 12: Day 1: 30 mg	3 x 10 mg	11	
Gemcitabine	1,000 mg/m² = 1,910 mg	1,910 mg	2 x 1,000 mg	8	16 x 1,000 mg
Oxaliplatin	100 mg/m² = 191 mg	191 mg	1 x 200 mg	8	8 x 200 mg
Appropriate comparator therapy					
Induction chemotherapy followed by high-dose chemotherapy with allogeneic stem cell transplant if there is a response to induction chemotherapy					
Induction therapy					
R-GDP (rituximab + gemcitabine + dexamethasone + cisplatin) [7]					
Rituximab	375 mg/m² = 716.3 mg	716.3 mg	1 x 500 mg + 3 x 100 mg	2 – 3	2.0 x 500 mg + 6.0 x 100 mg – 3.0 x 500 mg + 9.0 x 100 mg
Gemcitabine	1,000 mg/m² = 1,910 mg	1,910 mg	2 x 1,000 mg	4 – 6	8.0 x 1,000 mg –

Designation of the therapy	Dosage/ application	Dose/ patient/ treatment days	Consumption by potency/ treatment day	Treatment days/ patient/ year	Average annual consumption by potency
					12.0 x 1,000 mg
Dexamethasone	40 mg	40 mg	1 x 40 mg	8 – 12	8.0 x 40 mg – 12.0 x 40 mg
Cisplatin	75 mg/m^2 = 143.3 mg	143.3 mg	1 x 100 mg + 1 x 50 mg	2 – 3	2.0 x 100 mg + 2.0 x 50 mg – 3.0 x 100 mg + 3.0 x 50 mg
R-ICE (rituximab + ifosfamide + carboplatin + etoposide) [7, 8]					
Rituximab	375 mg/m^2 = 716.3 mg	716.3 mg	1 x 500 mg + 3 x 100 mg	3 – 4	3.0 x 500 mg + 9.0 x 100 mg – 4.0 x 500 mg + 12.0 x 100 mg
Ifosfamide	5,000 mg/m^2 = 9,550 mg	9,550 mg	2 x 5000 mg	2 – 3	4.0 x 5,000 mg – 6.0 x 5,000 mg
Carboplatin	AUC 5 (= 641.4 mg); max. 800 mg	641.4 mg – 800 mg	1 x 600 mg + 1 x 50 mg – 1 x 600 mg + 4 x 50 mg	2 – 3	2.0 x 600 mg + 2.0 x 50 mg - 3.0 x 600 mg + 3.0 x 50 mg – 2.0 x 600 mg + 8.0 x 50 mg - 3.0 x 600 mg + 12.0 x 50 mg
Etoposide	100 mg/m^2 = 191 mg	191 mg	1 x 200 mg	6 – 9	6.0 x 200 mg – 9.0 x 200 mg
R-DHAP (rituximab + dexamethasone + cytarabine + cisplatin) [7,8]					
Rituximab	375 mg/m^2 = 716.3 mg	716.3 mg	1 x 500 mg + 3 x 100 mg	2 – 4	2.0 x 500 mg + 6.0 x 100 mg – 4.0 x 500 mg + 12.0 x 100 mg
Dexamethasone	40 mg	40 mg	1 x 40 mg	8 – 12	8.0 x 40 mg – 12.0 x 40 mg
Cytarabine	2 x daily 2,000 mg/m^2	7,640 mg	4 x 2,000 mg	2 – 3	8.0 x 2,000 mg –

Designation of the therapy	Dosage/ application	Dose/ patient/ treatment days	Consumption by potency/ treatment day	Treatment days/ patient/ year	Average annual consumption by potency
	= 2 x 3,820 mg				12.0 x 2,000 mg
Cisplatin	100 mg/m² = 191 mg	191 mg	2 x 100 mg	2 – 3	4.0 x 100 mg – 6.0 x 100 mg

b2) Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for CAR-T cell therapy and a haematopoietic stem cell transplant after failure of two or more lines of systemic therapy

Designation of the therapy	Dosage/ application	Dose/ patient/ treatment days	Consumption by potency/ treatment day	Treatment days/ patient/ year	Average annual consumption by potency
Medicinal product to be assessed					
Glofitamab in combination with gemcitabine and oxaliplatin					
glofitamab	Cycle 1: Day 8: 2.5 mg	Cycle 1: Day 8: 2.5 mg	1 x 2.5 mg	1	1 x 2.5 mg + 34 x 10 mg
	Cycle 1: Day 15: 10 mg	Cycle 1: Day 15: 10 mg	1 x 10 mg	1	
	Cycle 2 – 12: Day 1: 30 mg	Cycle 2 – 12: Day 1: 30 mg	3 x 10 mg	11	
Gemcitabine	1,000 mg/m² = 1,910 mg	1,910 mg	2 x 1,000 mg	8	16 x 1,000 mg
Oxaliplatin	100 mg/m² = 191 mg	191 mg	1 x 200 mg	8	8 x 200 mg
Appropriate comparator therapy					
CAR-T cell therapies					
Axicabtagene ciloleucel	< 100 kg: 1 - 2 x 10^6 viable CAR+ T cells/kg	1 - 2 x 10^6/kg CAR+ T cells	1 single infusion bag	1	1 single infusion bag
	≥ 100 kg: 2 x 10^8 Viable CAR+ T cells	2 x 10^8 CAR+ T cells			

Designation of the therapy	Dosage/ application	Dose/ patient/ treatment days	Consumption by potency/ treatment day	Treatment days/ patient/ year	Average annual consumption by potency
	(from 100 kg regardless of body weight)				
Lisocabtagene maraleucel	100×10^6 viable CAR+ T cells	100×10^6 viable CAR+ T cells	1 single infusion bag	1	1 single infusion bag
Tisagenlecleucel	$0.6 - 6 \times 10^8$ CAR-positive viable T cells (regardless of the body weight)	$0.6 - 6 \times 10^8$ CAR-positive T cells	1 single infusion bag	1	1 single infusion bag
Tafasitamab in combination with lenalidomide					
Tafasitamab	12 mg/kg = 932.4 mg	932.4 mg	5 x 200 mg	33.0	165 x 200 mg
Lenalidomide	25 mg	25 mg	1 x 25 mg	252	252 x 25 mg
Polatuzumab vedotin in combination with bendamustine and rituximab					
Polatuzumab vedotin	1.8 mg/kg = 139.9 mg	139.9 mg	1 x 140 mg	6	6 x 140 mg
Bendamustine	90 mg/m^2 = 171.9 mg	171.9 mg	1 x 100 mg + 3 x 25 mg	12	12 x 100 mg + 36 x 25 mg
Rituximab	375 mg/m^2 = 716.3 mg	716.3 mg	1 x 500 mg + 3 x 100 mg	6	6 x 500 mg + 18 x 100 mg

Costs:

In order to improve comparability, the costs of the medicinal products were approximated both on the basis of the pharmacy sales price level and also deducting the statutory rebates in accordance with Section 130 and Section 130a SGB V. To calculate the annual treatment costs, the required number of packs of a particular potency was first determined on the basis of consumption. Having determined the number of packs of a particular potency, the costs of the medicinal products were then calculated on the basis of the costs per pack after deduction of the statutory rebates. Any reference prices shown in the cost representation may not represent the cheapest available alternative.

Inpatient treatments:

Calculation year	DRG	Average length of stay [d]	DRG valuation ratio (main department)	Federal base case value	Nursing revenue valuation ratio	Nursing fee	Case flat fee revenue	Nursing revenue	Total case flat fee revenue and nursing revenue
Appropriate comparator therapy									
High-dose chemotherapy with allogeneic stem cell transplant									
2025	R61G	7.9	1.061	€ 4,394.22	0.7864	€ 250	€ 4,662.27	€ 1,553.14	€ 6,215.41
2025	A04E	33.6	9.004	€ 4,394.22	1.7706	€ 250	€ 39,565.56	€ 14,873.04	€ 54,438.60

Costs of the medicinal products:

Designation of the therapy	Packaging size	Costs (pharmacy sales price)	Rebate Section 130 SGB V	Rebate Section 130a SGB V	Costs after deduction of statutory rebates
Medicinal product to be assessed					
Glofitamab in combination with gemcitabine and oxaliplatin					
Glofitamab 2.5 mg	1 CIS	€ 1,164.89	€ 1.77	€ 0.00	€ 1,163.12
Glofitamab 10 mg	1 CIS	€ 4,531.02	€ 1.77	€ 0.00	€ 4,529.25
Gemcitabine 1,000 mg	1 PIF	€ 102.35	€ 1.77	€ 10.62	€ 89.96
Oxaliplatin 200 mg	1 CIS	€ 395.68	€ 1.77	€ 18.24	€ 375.67
Appropriate comparator therapy					
Designation of the therapy	Packaging size	Costs (purchase price clinic pack plus value added tax)	Value-added tax (19 %)	Costs of the medicinal product	
CAR-T cell therapies					
Axicabtagene ciloleucel	1 single infusion bag	€ 230,621.00	€ 0[10]	€ 230,621.00	
Lisocabtagene maraleucel	1 single infusion bag	€ 227,500.00	€ 0[10]	€ 227,500.00	
Tisagenlecleucel	1 single infusion bag	€ 239,000.00	€ 0[10]	€ 239,000.00	

[10] The medicinal product is exempt from value added tax at the applied LAUER-TAXE® last revised.

Designation of the therapy	Packaging size	Costs (pharmacy sales price)	Rebate Section 130 SGB V	Rebate Section 130a SGB V	Costs after deduction of statutory rebates
Tafasitamab in combination with lenalidomide					
Tafasitamab 200 mg	1 PCI	€ 654.48	€ 1.77	€ 35.61	€ 617.10
Lenalidomide 25[11]	63 HC	€ 117.32	€ 1.77	€ 8.38	€ 107.17
Polatuzumab vedotin in combination with bendamustine and rituximab					
Polatuzumab vedotin 140 mg	1 PIC	€ 7,493.57	€ 1.77	€ 0.00	€ 7,491.80
Bendamustine 100 mg	5 PIC	€ 1,653.78	€ 1.77	€ 208.35	€ 1,443.66
Bendamustine 100 mg	1 PIC	€ 337.73	€ 1.77	€ 41.31	€ 294.65
Bendamustine 25 mg	5 PIC	€ 422.90	€ 1.77	€ 52.08	€ 369.05
Bendamustine 25 mg	1 PIC	€ 101.23	€ 1.77	€ 11.38	€ 88.08
Rituximab 100 mg	2 CIS	€ 717.21	€ 1.77	€ 39.08	€ 676.36
Rituximab 500 mg	1 CIS	€ 1,777.34	€ 1.77	€ 98.21	€ 1,677.36
Induction chemotherapies (R-GDP, R-DHAP, R-ICE) prior to allogeneic stem cell transplant					
Rituximab 100 mg	2 CIS	€ 717.21	€ 1.77	€ 39.08	€ 676.36
Rituximab 500 mg	1 CIS	€ 1,777.34	€ 1.77	€ 98.21	€ 1,677.36
Carboplatin 600 mg	1 CIS	€ 300.84	€ 1.77	€ 13.74	€ 285.33
Carboplatin 50 mg	1 CIS	€ 34.70	€ 1.77	€ 1.11	€ 31.82
Cisplatin 100 mg	1 CIS	€ 76.59	€ 1.77	€ 3.10	€ 71.72
Cisplatin 50 mg	1 CIS	€ 47.71	€ 1.77	€ 1.73	€ 44.21
Cytarabine 2,000 mg	1 SII	€ 77.06	€ 1.77	€ 3.12	€ 72.17
Dexamethasone 40 mg	10 TAB	€ 46.29	€ 1.77	€ 0.00	€ 44.29
Dexamethasone 40 mg	20 TAB	€ 81.59	€ 1.77	€ 0.00	€ 79.59
Etoposide 200 mg	1 CIS	€ 81.90	€ 1.77	€ 3.35	€ 76.78
Gemcitabine 1,000 mg	1 PIF	€ 102.35	€ 1.77	€ 10.62	€ 89.96
Ifosfamide 5 g	1 CIS	€ 177.77	€ 1.77	€ 7.90	€ 168.10

Abbreviations: HC = hard capsules; CIS = concentrate for the preparation of an infusion solution; SII = solution for injection/infusion; PIF = powder for the preparation of an infusion solution; PIC = powder for the preparation of an infusion solution concentrate; PCI = powder for a concentrate for the preparation of an infusion solution; TAB = tablets,

LAUER-TAXE® last revised: 01 September 2025

Costs for additionally required SHI services:

Only costs directly related to the use of the medicinal product are taken into account. If there are regular differences in the necessary use of medical treatment or in the prescription of other services in the use of the medicinal product to be evaluated and the appropriate comparator therapy in accordance with the product information, the costs incurred for this must be taken into account as costs for additionally required SHI services.

Medical treatment costs, medical fee services, and costs incurred for routine examinations

[11] Fixed reimbursement rate

(e.g. regular laboratory services such as blood count tests) that do not exceed the standard expenditure in the course of the treatment are not shown.

Non-prescription medicinal products that are reimbursable at the expense of the statutory health insurance according to Annex I of the Pharmaceuticals Directive (so-called OTC exception list) are not subject to the current medicinal products price regulation. Instead, in accordance with Section 129, paragraph 5a SGB V, when a non-prescription medicinal product is dispensed invoiced according Section 300, a medicinal product sale price applies to the insured person in the amount of the sale price of the pharmaceutical company plus the surcharges according to Sections 2 and 3 of the Pharmaceutical Price Ordinance in the valid version of 31 December 2003.

Prophylactic premedication

Antipyretic and antihistamine premedication is only recommended in the product information for axicabtagene ciloleucel, tisagenlecleucel and lisocabtagene maraleucel and is therefore not calculable.

Mesna is given in combination with ifosfamide for the prophylaxis of haemorrhagic cystitis.

During treatment with glofitamab, all patients receive antipyretic and antihistamine premedication in all cycles. In cycles 1 to 3, a glucocorticoid is also administered before all glofitamab infusions.

According to the product information for tafasitamab, patients should be pretreated with premedication, which may include antipyretics, antihistamines or corticosteroids, prior to administration of tafasitamab. This premedication is recommended during the first 3 infusions and is optional for subsequent infusions. The product information does not provide any specific information why the necessary costs cannot be quantified for the premedication.

Conditioning chemotherapy for lymphocyte depletion under CAR-T cell therapy

Axicabtagene ciloleucel is an autologous cell product produced from the patient's own T cells. Therefore, a leukapheresis is usually necessary to obtain the cell material. Since leukapheresis is part of the manufacture of the medicinal product pursuant to Section 4, paragraph 14 Medicinal Products Act, no further costs are incurred in this respect for axicabtagene ciloleucel.

For axicabtagene ciloleucel and lisocabtagene maraleucel, a treatment regimen for lymphocyte depletion, consisting of intravenous administration of cyclophosphamide (500 mg/m^2 = 955 mg) and fludarabine (30 mg/m^2 = 57.3 mg), is given daily for 3 days, with infusion administered 3 to 5 days after the start of lymphocyte depletion.

For tisagenlecleucel, provided the white blood cell count is not below ≤ 1,000 cells/µl one week prior to infusion, a treatment regimen for lymphocyte depletion, consisting of intravenous administration of fludarabine (25 mg/m^2 = 47.75 mg) and cyclophosphamide (250 mg/m^2= 477.5 mg) daily over 3 days starting with the first fludarabine dose, with tisagenlecleucel infusion administered 2 to 14 days after the start of lymphocyte depletion.

Screening for hepatitis B virus (HBV), hepatitis C virus (HCV) and human immunodeficiency virus (HIV) under CAR-T cell therapy

Patients should be tested for hepatitis B, hepatitis C and HIV infection prior to starting treatment with axicabtagene ciloleucel, lisocabtagene maraleucel, or tisagenlecleucel. This

test is not required for all therapy options of the appropriate comparator therapy. Since there is a regular difference between the medicinal product to be assessed and the appropriate comparator therapy with regard to the tests for hepatitis B, hepatitis C and HIV, the costs of additionally required SHI services are presented in the resolution.

Patients should be tested for hepatitis B infection prior to starting treatment with rituximab and lenalidomide.

Diagnostics to rule out chronic hepatitis B requires sensibly coordinated steps. A step-by-step serological diagnosis initially consists of the examination of HBs antigen and anti-HBc antibodies. If both are negative, a past HBV infection can be excluded. In certain case constellations, further steps may be necessary in accordance with current guideline recommendations.[12]

[12] S3 guideline on prevention, diagnosis and therapy of hepatitis B virus infection; AWMF registry no.: 021/011 https://register.awmf.org/assets/guidelines/021-011l_S3_Prophylaxe-Diagnostik-Therapie-der-Hepatitis-B-Virusinfektion_2021-07.pdf

Designation of the therapy	Packaging size	Costs (pharmacy sales price)	Rebate Section 130 SGB V	Rebate Section 130a SGB V	Costs after deduction of statutory rebates	Treatment days/ year	Costs/ patient/ year
Medicinal product to be assessed							
Glofitamab in combination with gemcitabine and oxaliplatin							
glofitamab							
Dexamethasone[11] 20 mg, IV	10 SFI 4 mg each	€ 16.92	€ 1.77	€ 0.44	€ 14.71	4	€ 29.42
Dimetindene IV (1 mg/10 kg BW = 7.8 mg, IV)	5 SFI 4 mg each	€ 26.24	€ 1.77	€ 6.92	€ 17.55	13	€ 105.30
Paracetamol[11] 500 – 1,000 mg	20 TAB 500 mg each 10 TAB each 1,000 mg	€ 3.47 € 3.32	€ 0.17 € 0.17	€ 0.15 € 0.14	€ 3.15 € 3.01	13	3.15 – € 6.02
Appropriate comparator therapy:							
CAR-T cell therapies							
Screening for HBV, HCV and HIV							
HBV test Hepatitis B surface antigen status (GOP 32781)	-	-	-	-	€ 5.06	1.0	€ 5.06
Anti-HBc antibody (GOP 32614)	-	-	-	-	€ 5.43	1.0	€ 5.43
Hepatitis C HCV antibody status (GOP 32618)	-	-	-	-	€ 9.02	1.0	€ 9.02
HIV HIV-1 and HIV-2 antibody status (GOP: 32575)	-	-	-	-	€ 4.09	1.0	€ 4.09
Axicabtagene ciloleucel							
Conditioning chemotherapy for lymphocyte depletion							
Cyclophosphamide 500 mg/m^2 = 955 mg	6 PSI each 500 mg	€ 85.98	€ 1.77	€ 9.45	€ 74.76	3.0	€ 74.76
Fludarabine 30 mg/m^2 = 57.3 mg	1 KII at 50 mg	€ 118.54	€ 1.77	€ 5.09	€ 111.68	3.0	€ 670.08
Tisagenlecleucel							

Designation of the therapy	Packaging size	Costs (pharmacy sales price)	Rebate Section 130 SGB V	Rebate Section 130a SGB V	Costs after deduction of statutory rebates	Treatment days/ year	Costs/ patient/ year
Conditioning chemotherapy for lymphocyte depletion							
Cyclophosphamide 250 mg/m² = 477.5 mg	10 PIJ at 200 mg	€ 70.83	€ 1.77	€ 3.29	€ 65.77	3.0	€ 65.77
Fludarabine 25 mg/m² = 47.75 mg	1 KII at 50 mg	€ 118.54	€ 1.77	€ 5.09	€ 111.68	3.0	€ 670.08
Lisocabtagene maraleucel							
Conditioning chemotherapy for lymphocyte depletion							
Cyclophosphamide 300 mg/m² = 573 mg	6 PSI each 500 mg	€ 85.98	€ 1.77	€ 9.45	€ 74.76	3.0	€ 74.76
Fludarabine 30 mg/m² = 57.3 mg	1 KII at 50 mg	€ 118.54	€ 1.77	€ 5.09	€ 111.68	3.0	€ 670.08
Induction chemotherapies (R-GDP, R-DHAP, R-ICE) prior to allogeneic stem cell transplant							
Rituximab (R-GDP, R-DHAP, R-ICE)							
HBV diagnostics							
HBV test Hepatitis B surface antigen status (GOP 32781)	-	-	-	-	€ 5.06	1.0	€ 5.06
Anti-HBc antibody (GOP 32614)	-	-	-	-	€ 5.43	1.0	€ 5.43
Premedication (R-GDP)							
Dimetindene IV 1 mg/ 10 kg = 7.8 mg	5 SFI at 4 mg	€ 26.24	€ 1.77	€ 6.92	€ 17.55	2.0 – 3.0	€ 17.55 – € 35.10
Paracetamol[11] (500 mg - 1,000 mg, PO)	10 TAB 500 mg – 10 TAB 1,000 mg	€ 2.96 – € 3.32	€ 0.15 – € 0.17	€ 0.13 – € 0.14	€ 2.68 – € 3.01	2.0 – 3.0	€ 2.68 – € 3.01
Premedication (R-DHAP)							
Dimetindene IV 1 mg/ 10 kg = 7.8 mg	5 SFI at 4 mg	€ 26.24	€ 1.77	€ 6.92	€ 17.55	2.0 – 3.0	€ 17.55 – € 35.10
Paracetamol[11] (500 mg - 1,000 mg, PO)	10 TAB 500 mg – 10 TAB 1,000 mg	€ 2.96 – € 3.32	€ 0.15 – € 0.17	€ 0.13 – € 0.14	€ 2.68 – € 3.01	2.0 – 4.0	€ 2.68 – € 3.01
Premedication (R-ICE)							
Dimetindene IV 1 mg/ 10 kg	5 SFI at 4 mg	€ 26.24	€ 1.77	€ 6.92	€ 17.55	2.0 –	€ 17.55 –

Designation of the therapy	Packaging size	Costs (pharmacy sales price)	Rebate Section 130 SGB V	Rebate Section 130a SGB V	Costs after deduction of statutory rebates	Treatment days/ year	Costs/ patient/ year
= 7.8 mg						3.0	€ 35.10
Paracetamol[11] (500 mg - 1,000 mg, PO)	10 TAB 500 mg – 10 TAB 1,000 mg	€ 2.96 – € 3.32	€ 0.15 – € 0.17	€ 0.13 – € 0.14	€ 2.68 – € 3.01	3.0 – 4.0	€ 2.68 – € 3.01
Cisplatin (R-GDP, R-DHAP)							
Antiemetic treatment: In clinical practice, an appropriate antiemetic treatment is established before and/or after administration of cisplatin. The product information for cisplatin does not provide any specific information on this, which is why the necessary costs cannot be quantified.							
Mannitol 10% Inf. sol., 37.5 g/day	10 x 250 ml INF	€ 87.05	€ 4.35	€ 7.94	€ 74.76	2.0 – 3.0	€ 74.76
Sodium chloride 0.9% Inf. sol., 3 l - 4.4 l/day	10 x 1,000 ml INF	€ 23.10	€ 1.16	€ 1.89	€ 20.05	2.0 – 3.0	€ 40.01 – € 80.02
Mesna (R-ICE)							
Mesna (Bolus with 1,900 mg mesna (= 20% of the ifosfamide dose), followed by 24-hour continuous infusion with at least 1,900 mg up to 9,500 mg (= 20% - 100% of the ifosfamide dose), followed by subsequent infusion with up to 4,750 mg mesna (= 0% - 50% of the ifosfamide dose) for 6 - 12 hours	Bolus with 1,900 mg followed by 24-hour continuous infusion with 1,900 mg						
	5 SFI x 1,000 mg	€ 48.54	€ 1.77	€ 1.77	€ 45.00	2.0 – 3.0	€ 90.00 – € 135.00
	Bolus of 1,900 mg followed by 24-hour continuous infusion of 9,500 mg followed by subsequent infusion of 4,750 mg						
	50 AMP x 400 mg	€ 151.06	€ 1.77	€ 17.68	€ 131.61	2.0 – 3.0	€ 266.06 - € 352.12
	5 SFI x 1,000 mg	€ 48.54	€ 1.77	€ 1.77	€ 45.00		
Polatuzumab vedotin in combination with bendamustine and rituximab							
Rituximab							
Dimetindene IV (1 mg/10 kg BW = 7.8 mg, IV)	5 SFI 4 mg each	€ 26.24	€ 1.77	€ 6.92	€ 17.55	6	€ 52.65
Paracetamol[11] 500 – 1,000 mg	10 TAB 500 mg each	€ 2.96 – € 3.32	€ 0.15 – € 0.17	€ 0.13 – € 0.14	€ 2.68 – € 3.01	6	€ 2.68 – € -3.01

Designation of the therapy	Packaging size	Costs (pharmacy sales price)	Rebate Section 130 SGB V	Rebate Section 130a SGB V	Costs after deduction of statutory rebates	Treatment days/ year	Costs/ patient/ year
	10 TAB each 1,000 mg						
HBV diagnostics							
Hepatitis B Surface antigen status (GOP: 32781)	-	-	-	-	€ 5.06	1	€ 5.06
Hepatitis B HBV antibody status (GOP: 32614)	-	-	-	-	€ 5.43	1	€ 5.43
Tafasitamab in combination with lenalidomide							
Lenalidomide							
HBV diagnostics							
Hepatitis B Surface antigen status (GOP: 32781)	-	-	-	-	€ 5.06	1	€ 5.06
Hepatitis B HBV antibody status (GOP: 32614)	-	-	-	-	€ 5.43	1	€ 5.43
Abbreviations: AMP = ampoules; SFI = solution for injection, INF = infusion solution; CII = concentrate for injection or infusion solution, PSI = powder for solution for injection, TAB = tablets							

Other SHI services:

The special agreement on contractual unit costs of retail pharmacist services (Hilfstaxe) (Sections 4 and 5 of the Pharmaceutical Price Ordinance) from 1 October 2009 is not fully used to calculate costs. Alternatively, the pharmacy sales price publicly accessible in the directory services according to Section 131 paragraph 4 SGB V is a suitable basis for a standardised calculation.

According to the currently valid version of the special agreement on contractual unit costs of retail pharmacist services (Hilfstaxe), surcharges for the production of parenteral preparations containing cytostatic agents a maximum amount of € 100 per ready-to-use preparation, and for the production of parenteral solutions containing monoclonal antibodies a maximum of € 100 per ready-to-use unit are to be payable. These additional other costs are not added to the pharmacy sales price but rather follow the rules for calculating in the Hilfstaxe. The cost representation is based on the pharmacy retail price and the maximum surcharge for the preparation and is only an approximation of the treatment costs. This presentation does not take into account, for example, the rebates on the pharmacy purchase price of the active ingredient, the invoicing of discards, the calculation of application containers, and carrier solutions in accordance with the regulations in Annex 3 of the Hilfstaxe.

2.5 Designation of medicinal products with new active ingredients according to Section 35a, paragraph 3, sentence 4 SGB V that can be used in a combination therapy with the assessed medicinal product

According to Section 35a, paragraph 3, sentence 4, the G-BA designate all medicinal products with new active ingredients that can be used in a combination therapy with the assessed medicinal product for the therapeutic indication to be assessed on the basis of the marketing authorisation under Medicinal Products Act.

Basic principles of the assessed medicinal product

A designation in accordance with Section 35a, paragraph 3, sentence 4 SGB V requires that it is examined based on the product information for the assessed medicinal product whether it can be used in a combination therapy with other medicinal products in the assessed therapeutic indication. In the first step, the examination is carried out on the basis of all sections of the currently valid product information for the assessed medicinal product.

If the assessed medicinal product contains an active ingredient or a fixed combination of active ingredients in the therapeutic indication of the resolution (assessed therapeutic indication) and is approved exclusively for use in monotherapy, a combination therapy is not considered due to the marketing authorisation under Medicinal Products Act, which is why no designation is made.

A designation is also not considered if the G-BA have decided on an exemption as a reserve antibiotic for the assessed medicinal product in accordance with Section 35a, paragraph 1c, sentence 1 SGB V. The additional benefit is deemed to be proven if the G-BA have decided on an exemption for a reserve antibiotic in accordance with Section 35a, paragraph 1c, sentence 1 SGB V; the extent of the additional benefit and its therapeutic significance are not to be assessed by the G-BA. Due to the lack of an assessment mandate by the G-BA following the resolution on an exemption according to Section 35a, paragraph 1c, sentence 1 SGB V with regard to the extent of the additional benefit and the therapeutic significance of the reserve antibiotic to be assessed, there is a limitation due to the procedural privileging of the pharmaceutical companies to the effect that neither the proof of an existing nor an expected at least considerable additional benefit is possible for exempted reserve antibiotics in the procedures according to Section 35a paragraph 1 or 6 SGB V and Section 35a paragraph 1d SGB V. The procedural privileging of the reserve antibiotics exempted according to Section 35a, paragraph 1c, sentence 1 SGB V must therefore also be taken into account at the level of designation according to Section 35a, paragraph 3, sentence 4 SGB V in order to avoid valuation contradictions.

With regard to the further examination steps, a differentiation is made between a "determined" or "undetermined" combination, which may also be the basis for a designation.

A "determined combination" exists if one or more individual active ingredients which can be used in combination with the assessed medicinal product in the assessed therapeutic indication are specifically named.

An "undetermined combination" exists if there is information on a combination therapy, but no specific active ingredients are named. An undetermined combination may be present if the information on a combination therapy:

- names a product class or group from which some active ingredients not specified in detail can be used in combination therapy with the assessed medicinal product, or

- does not name any active ingredients, product classes or groups, but the assessed medicinal product is used in addition to a therapeutic indication described in more detail in the relevant product information, which, however, does not include information on active ingredients within the scope of this therapeutic indication.

Concomitant active ingredient

The concomitant active ingredient is a medicinal product with new active ingredients that can be used in combination therapy with the assessed medicinal product for the therapeutic indication to be assessed.

For a medicinal product to be considered as a concomitant active ingredient, it must be classified as a medicinal product with new active ingredients according to Section 2 paragraph 1 Ordinance on the Benefit Assessment of Pharmaceuticals (AM-NutzenV) in conjunction with the corresponding regulations in Chapter 5 of the Rules of Procedure of the G-BA as of the date of the present resolution. In addition, the medicinal product must be approved in the assessed therapeutic indication, whereby a marketing authorisation is sufficient only for a sub-area of the assessed therapeutic indication.

Based on an "undetermined combination", the concomitant active ingredient must be attributable to the information on the product class or group or the therapeutic indication according to the product information of the assessed medicinal product in the assessed therapeutic indication, whereby the definition of a product class or group is based on the corresponding requirements in the product information of the assessed medicinal product.

In addition, there must be no reasons for exclusion of the concomitant active ingredient from a combination therapy with the assessed medicinal product, in particular no exclusive marketing authorisation as monotherapy.

In addition, all sections of the currently valid product information of the eligible concomitant active ingredient are checked to see whether there is any information that excludes its use in combination therapy with the assessed medicinal product in the assessed therapeutic indication under marketing authorisation regulations. Corresponding information can be, for example, dosage information or warnings. In the event that the medicinal product is used as part of a determined or undetermined combination which does not include the assessed medicinal product, a combination with the assessed medicinal product shall be excluded.

Furthermore, the product information of the assessed medicinal product must not contain any specific information that excludes its use in combination therapy with the eligible concomitant active ingredient in the assessed therapeutic indication under marketing authorisation regulations.

Medicinal products with new active ingredients for which the G-BA have decided on an exemption as a reserve antibiotic in accordance with Section 35a, paragraph 1c, sentence 1 SGB V are ineligible as concomitant active ingredients. The procedural privileging of the reserve antibiotics exempted according to Section 35a, paragraph 1c, sentence 1 SGB V also applies accordingly to the medicinal product eligible as a concomitant active ingredient.

Designation

The medicinal products which have been determined as concomitant active ingredients in accordance with the above points of examination are named by indicating the relevant active ingredient and the invented name. The designation may include several active ingredients, provided that several medicinal products with new active ingredients may be used in the same

combination therapy with the assessed medicinal product or different combinations with different medicinal products with new active ingredients form the basis of the designation.

If the present resolution on the assessed medicinal product in the assessed therapeutic indication contains several patient groups, the designation of concomitant active ingredients shall be made separately for each of the patient groups.

Exception to the designation

The designation excludes combination therapies for which - patient group-related - a considerable or major additional benefit has been determined by resolution according to Section 35a, paragraph 3, sentence 1 SGB V or it has been determined according to Section 35a, paragraph 1d, sentence 1 SGB V that at least considerable additional benefit of the combination can be expected. In this context, the combination therapy that is excluded from the designation must, as a rule, be identical to the combination therapy on which the preceding findings were based.

In the case of designations based on undetermined combinations, only those concomitant active ingredients - based on a resolution according to Section 35a, paragraph 3, sentence 1 SGB V on the assessed medicinal product in which a considerable or major additional benefit had been determined - which were approved at the time of this resolution are excluded from the designation.

Legal effects of the designation

The designation of combinations is carried out in accordance with the legal requirements according to Section 35a, paragraph 3, sentence 4 and is used exclusively to implement the combination discount according to Section 130e SGB V between health insurance funds and pharmaceutical companies. The designation is not associated with a statement as to the extent to which a therapy with the assessed medicinal products in combination with the designated medicinal products corresponds to the generally recognised state of medical knowledge. The examination was carried out exclusively on the basis of the possibility under Medicinal Products Act to use the medicinal products in combination therapy in the assessed therapeutic indication based on the product information; the generally recognised state of medical knowledge or the use of the medicinal products in the reality of care were not the subject of the examination due to the lack of an assessment mandate of the G-BA within the framework of Section 35a, paragraph 3, sentence 4 SGB V.

The findings made neither restrict the scope of treatment required to fulfil the medical treatment mandate, nor do they make statements about expediency or economic feasibility.

Justification for the findings on designation in the present resolution:

Adults with relapsed or refractory diffuse large B-cell lymphoma not otherwise specified (DLBCL NOS) who are ineligible for autologous stem cell transplant (ASCT)

No medicinal product with new active ingredients that can be used in a combination therapy that fulfils the requirements of Section 35a, paragraph 3, sentence 4 SGB V.
References:
Product information for glofitamab (Columvi); Columvi®; last revised: July 2025

References: Product information of lisocabtagene maraleucel (Breyanzi); BREYANZI® 1.1 - 70 × 10^6 cells/ml / 1.1 - 70 × 10^6 cells/ml infusion dispersion; last revised: September 202

3. Bureaucratic costs calculation

The proposed resolution does not create any new or amended information obligations for care providers within the meaning of Annex II to Chapter 1 VerfO and, accordingly, no bureaucratic costs.

4. Process sequence

At their session on 27 July 2021, the Subcommittee on Medicinal Products determined the appropriate comparator therapy.

A review of the appropriate comparator therapy took place once the marketing authorisation was granted. The Subcommittee on Medicinal Products determined the appropriate comparator therapy at their session on 6 May 2025.

On 9 May 2025 the pharmaceutical company submitted a dossier for the benefit assessment of glofitamab to the G-BA in due time in accordance with Chapter 5 Section 8, paragraph 1, number 2 VerfO.

By letter dated 14 May 2025 in conjunction with the resolution of the G-BA of 1 August 2011 concerning the commissioning of the IQWiG to assess the benefit of medicinal products with new active ingredients in accordance with Section 35a SGB V, the G-BA commissioned the IQWiG to assess the dossier concerning the active ingredient glofitamab.

The dossier assessment by the IQWiG was submitted to the G-BA on 12 August 2025, and the written statement procedure was initiated with publication on the G-BA website on 15 August 2025. The deadline for submitting statements was 5 September 2025.

The oral hearing was held on 22 September 2025.

In order to prepare a recommendation for a resolution, the Subcommittee on Medicinal Products commissioned a working group (Section 35a) consisting of the members nominated by the leading organisations of the care providers, the members nominated by the SHI umbrella organisation, and representatives of the patient organisations. Representatives of the IQWiG also participate in the sessions.

The evaluation of the written statements received and the oral hearing was discussed at the session of the Subcommittee on 28 October 2025, and the proposed draft resolution was approved.

At their session on 6 November 2025, the plenum adopted a resolution to amend the Pharmaceuticals Directive.

Chronological course of consultation

Session	Date	Subject of consultation
Subcommittee on Medicinal Products	27 July 2021	Determination of the appropriate comparator therapy
Subcommittee on Medicinal Products	6 May 2025	New determination of the appropriate comparator therapy
Working group Section 35a	3 September 2025	Information on written statements received; preparation of the oral hearing
Subcommittee on Medicinal Products	22 September 2025	Conduct of the oral hearing
Working group Section 35a	1 October 2025; 15 October 2025	Consultation on the dossier evaluation by the IQWiG and evaluation of the written statement procedure
Subcommittee on Medicinal Products	28 October 2025	Concluding discussion of the draft resolution
Plenum	6 November 2025	Adoption of the resolution on the amendment of the Pharmaceuticals Directive

Berlin, 06 November 2025

Federal Joint Committee (G-BA)
in accordance with Section 91 SGB V
The Chair

Prof. Hecken